# MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6217

-62-047246 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

FILED JAN 7 1963

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Kansas City
Length of stay in 1b: 3 Weeks
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Trinity Luthern Hosp. Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Buchanan
c. CITY OR TOWN: St. Joseph Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 2925 Faraon Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Morris Middle: L. Last: Tropp

4. DATE OF DEATH: Month: December Day: 5 Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH

9. AGE (last birthday): Approx. 55 IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Physician

10b. KIND OF BUSINESS OR INDUSTRY: Medical

11. BIRTHPLACE (City and state or country): Atlanta, Georgia

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Abraham Tropp

13b. MOTHER'S MAIDEN NAME: Ann Hyman

14. NAME OF HUSBAND OR WIFE: Mollie Tropp

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: ----------

17. INFORMANT: Mollie Tropp Address: St. Joseph, Mo. 2925 Faraon

18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY:)

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Cardiac Arrest - Postoperative - (Mitral Commissurotomy) | 1 hr Post op |
| DUE TO (b) | | |
| DUE TO (c) | Rheumatic heart disease, inactive | 1½ yrs |

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Left Hemiplegia from Cerebral Arterial Embolism 11-17-62

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from Nov 17, 1962, to Dec 5, 1962 and last saw him alive on Dec 5, 1962

Death occurred at 5 35 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

MEDICAL CERTIFICATION

22a. SIGNATURE (Degree or title): Edward H. Fischer M.D.

22b. ADDRESS: 306 E 21st N KC 16 Mo

22c. DATE SIGNED: 12-6-62

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 12/7/1962

23c. NAME OF CEMETERY OR CREMATORY: Sheffield Cemetery

23d. LOCATION (City, town, or county) (State): Kansas City, Missouri

24. FUNERAL DIRECTOR ADDRESS: J. P. Louis Funeral Home, K. C., Mo.

25. DATE RECD. BY LOCAL REG.: 12-7-62

26. REGISTRAR'S SIGNATURE: Ruth Long

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

| ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED |
|---|---|---|---|
| 1 | | | |
| 2 | 5117 | | |
| 3 | | | |
| 4 | C | | |
| 5 | 1 | | |
| 6 | | | |
| 7 | 1 | | |
| 8 | 2 | | |
| 9 | 4 10X | | |
| 10 | | | |
| 11 | | | |
| 12 | 68.0 | | |
| 13 | | | |

BY AFFIDAVIT OF - DOCUMENT

USE BLACK INK OR TYPEWRITER RIBBON

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Student Embalmer No._____ working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Dewy Buffington

Licensed Embalmer No. 2756

P. O. Address [illegible]

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.